# Table of Contents

## ARTICLE I Introduction

1.1 Definitions .................................................................................................. 4 - 5

## ARTICLE II Admission and Discharge

2.1 Admissions ................................................................................................ 6 - 7
2.2 Coverage and Call ..................................................................................... 7 - 9
2.3 Transfers ...................................................................................................... 10
2.4 Patients Who Are a Danger to Themselves or Others ................................. 10
2.5 Prompt Assessment ..................................................................................... 10
2.6 Discharge Orders and Instructions .............................................................. 11
2.7 Discharge Against Medical Advice ............................................................... 11

## ARTICLE III Medical Records

3.1 Authentication of Entries ............................................................................. 11
3.2 Clarity, Legibility, and Completeness .................................................... 11 - 12
3.3 Abbreviations and Symbols ......................................................................... 12
3.4 Correction of Errors ..................................................................................... 12
3.5 History and Physical Examination ............................................................. 12 - 13
3.6 Pre-operative Documentation .................................................................... 13
3.7 Progress Notes ...................................................................................... 13 - 14
3.8 Operative/Procedure Reports ....................................................................... 14
3.9 Operative/Procedure Notes ......................................................................... 14
3.10 Anesthesia Assessments .............................................................................. 14
3.11 Consultations ............................................................................................... 14
3.12 Obstetrical Record ....................................................................................... 14
3.13 Discharge Summaries .................................................................................. 15
3.14 Diagnostic Reports ....................................................................................... 16
3.15 Authentication Of Outside Records ............................................................. 16
3.16 Access and Confidentiality .......................................................................... 16
3.17 Medical Record Completion ................................................................ 17 – 18
3.18 Medical Students ......................................................................................... 18

## ARTICLE IV Standards of Practice

4.1 Attending Physician ..................................................................................... 18
4.2 Responding to Calls and Pages .................................................................... 19
4.3 Orders .................................................................................................. 19 - 20
## Table of Contents

**ARTICLE IV** Standards of Practice

4.4 Consultation................................................................. 20 - 21  
4.5 Death in Hospital ......................................................... 21  
4.6 Autopsy ........................................................................ 22  
4.7 Advanced Practice Professionals ............................... 22 - 23  
4.8 Infection Control .......................................................... 24  
4.9 Evidence Based Medicine Order Sets .......................... 24  

**ARTICLE V** Patient Rights

5.1 Patient Rights............................................................... 24  
5.2 Informed Consent .......................................................... 24  
5.3 Withholding or Withdrawing Life-Sustaining Treatment 24  
5.4 Do-Not-Resuscitate Orders .......................................... 24  
5.5 Disclosure of Unanticipated Outcomes ......................... 25  
5.6 Restraints and Seclusion .............................................. 25  
5.7 Advance Directives ...................................................... 25  
5.8 Investigational Studies ................................................ 25  

**ARTICLE VI** Surgical Care

6.1 Surgical Privileges ........................................................ 25  
6.2 Surgical Policies and Procedures .................................... 25  
6.3 Anesthesia ..................................................................... 26  
6.4 Tissue Specimens .......................................................... 26  
6.5 Verification of Correct Patient, Site, and Procedure ......... 26  

**ARTICLE VII** Rules of Conduct

7.1 Disruptive Behavior ....................................................... 26 – 27  
7.2 Reporting Impaired Practitioners .................................... 27  

References ............................................................................ 28 - 29
ARTICLE I
INTRODUCTION

These Rules and Regulations are adopted by the Medical Staff of St. Anthony’s Memorial Hospital and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of healthcare should not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff shall be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff Rules and Regulations pertaining to the subject matter thereof.

1.1 Definitions

“ADMITTING PHYSICIAN” means the practitioner accepting the admission.

“ADVANCE DIRECTIVE” means a document or documentation allowing an individual to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives include a Living Will, Do-Not-Resuscitate Orders and similar documents expressing the individual’s preferences as specified in the Patient Self-Determination Act.

“APPOINTEE” means any medical physician, osteopathic physician, dentist or podiatrist holding a current license to practice, who is a member of the Medical Staff.

“ATTENDING PHYSICIAN” means the practitioner who has accepted responsibility for the ongoing care of the patient in the hospital.

“CLINICAL PRIVILEGES” the permission granted by the Board of Directors to a Practitioner to render or exercise specific diagnostic, therapeutic, medical, surgical services and/or procedures in the Hospital.

"COVERAGE" the obligation of all physicians to provide 24 hour medical care for their own patients.

“ELECTRONIC RECORDS AND SIGNATURES” any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to State and Federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.
“EMERGENCY MEDICAL CONDITION” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part or with respect to a pregnant woman who is having contractions, (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or unborn child.

“FAMILY” means those persons who play a significant role in the individual’s life. This may include persons who are not legally related to the individual.

“LIFE-SUSTAINING PROCEDURE” means a medical procedure or intervention which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

“HEALTH CARE AGENT” means an individual designated in a health care power of attorney to make health care decisions on behalf of a person who is incapacitated.

“HOSPITAL” means St. Anthony’s Memorial Hospital and includes all of its related facilities and all of its personnel and organizational entities, including the Medical Staff.

“INVASIVE PROCEDURE” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

“PATIENT” means any individual undergoing diagnostic evaluation or receiving medical treatment at the Hospital.

“PHYSICIAN” A Doctor of Medicine (MD), a Doctor of Podiatric Medicine (DPM), a Doctor of Osteopathy (DO), or an Oral/Maxillofacial surgeon licensed to practice in the State of Illinois.

“PRACTITIONER” Any individual who has been granted Clinical Privileges by the Board of Directors.

“SURGEON” refers to any practitioner performing an operation or invasive procedure on a patient, and is not limited to members of the Surgery Clinical Service.

“UNABLE TO CONSENT” or “INCOMPETENT” means unable to appreciate the nature and implications of the patient’s condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does include minors unless they are married or have been determined judicially to be emancipated.

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.
ARTICLE II
ADMISSION AND DISCHARGE

2.1 Admissions

2.1.1 General

The hospital accepts short term patients for care and treatment provided suitable facilities are available.

a. Admitting Privileges: A patient may be admitted to the hospital only by an appointee to the Medical Staff with admitting privileges.

b. Admitting Diagnosis: Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been entered in the medical record. In the case of emergency, such statement shall be recorded as soon as possible.

c. Admission Procedure: Emergency admissions shall be scheduled with the Shift Supervisor. A bed shall be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Urgent and elective admissions can be sent to Registration, however a call to the Shift Supervisor is encouraged.

2.1.2 Admission Priority

The Shift Supervisor shall facilitate the placement of patients on the basis of the following order of priorities:

a. Emergency Admission: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient shall be admitted immediately to the first appropriate bed available.

b. Urgent Admission: Urgent admission patients meet the criteria for admission, however their condition is not life-threatening. Urgent admission patients shall be admitted as soon as an appropriate bed is available.

c. Elective Admission: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health’s sake. These patients may be admitted on a first-come, first-serve basis. A waiting list shall be kept and each patient shall be admitted as soon as a bed becomes available.
2.1.3 Assignment to Appropriate Service Areas

Every effort shall be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care should be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor shall be admitted directly to the LDR (Labor, Delivery, and Recovery).

2.2 Coverage and Call

2.2.1 Coverage

a. All physicians shall provide coverage for their own patients. If there are failures in response, this shall be reported to the Medical Executive Committee (MEC). Coverage schedules are to be complete and any issues with coverage shall be addressed by the MEC.

b. **Response Time:** It is the responsibility of the physician to respond in an appropriate time frame. Physicians should respond to calls from the Emergency Department or the Hospital within 30 minutes. If required by the Emergency Department physician, it is expected that physicians arrive in the Emergency Department within 1 hour of initial contact or at a time determined by the Emergency Department physician. If a physician does not respond to being called or paged within 30 minutes, the nursing staff shall follow current call protocols. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage:**

1. In the event a physician is unable to fulfill his/her coverage obligation, it is his/her responsibility to arrange for a substitute and notify the Emergency Department. Failure to notify the Emergency Department of a substitute may result in the initiation of disciplinary action.

2. Each Physician shall provide the Medical Staff Services Office with the name of at least one (1) designated Medical Staff appointee with as close to similar privileges as reasonable (usually a member of his/her group practice and have equivalent clinical and procedure privileges) who shall be responsible for coverage obligations, the care of their patients in the Hospital and for outpatient follow-up when the Physician is not available. The designated Physician must acknowledge and consent to the coverage arrangement. In cases where the Physician is in a specialty where obtaining substitute coverage is difficult (i.e., where there are only two physicians on staff in a particular specialty), the Physician’s substitute coverage plan is subject to advance review and approval by the Medical Executive Committee.
2.2.2 Call

a. For the purposes of this document, call schedule, refers to an Emergency Department EMTALA (Emergency Medical Treatment and Active Labor Act) required call schedule.

b. **Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an Emergency Medical Condition. Nothing contained in this provision shall be construed to mean that a physician will be required to provide or should provide call coverage which is outside of, or inconsistent with, the physician’s granted clinical privileges at the hospital. Services that are required to have a call schedule will be determined by the MEC. The Clinical Service Chiefs shall be responsible for placing physicians on the call schedule. Call shall be from 0700 to 0659 the following day, unless other times are mutually agreed upon by the majority of physicians on that call schedule. Call schedules shall be published 30 days in advance. Call schedules shall also be used by the Emergency Department for unassigned patients and for consults for hospitalized patients.

c. **Guidelines for Determining Call Schedules**: The Hospital shall charge the MEC with undertaking an analysis, of all relevant factors, to identify how the Hospital’s call schedules can best meet the needs of the community, in accordance with the resources available. The call schedules shall be EMTALA compliant. Following analysis by the MEC, their recommendation shall be sent to the Board of Directors for review and approval. This process shall be undertaken at least once per calendar year to allow for changes in resources and capabilities of the Hospital and Medical Staff. The MEC shall determine to which call schedule a multi-specialty physician may be assigned.

d. Newly appointed Medical Staff members shall be exempt from call for 1 month from date of Medical Staff membership.

e. The maximum call requirement for all Medical Staff members shall be 1 out of every 4 days. The MEC may adjust this requirement, if necessary, following consensus from all physicians in that specialty.

f. An impairment which is alleged to limit a physician’s ability to participate in a call schedule shall be grounds for limiting the physician’s privileges for providing care to all patients.

g. Exemption from call shall be granted to Physicians who are at least 60 years of age AND have been on staff at St. Anthony’s for at least 10 years by petitioning the MEC for approval. Requests for exemption must be requested at least 12 months in advance of the effective date of exemption. The MEC shall act upon the request at their next regularly scheduled MEC meeting.
h. Any other requests for exemption from call responsibilities shall be considered extraordinary and must first be approved by a majority of the physicians on that call schedule. The MEC and the Board of Directors shall be responsible for granting exemptions.

i. Unless otherwise indicated by the patient’s clinical condition, Emergency Services physicians shall make specialty referrals in the following order:

- Patient’s preference or covering physician; or
- Patient’s primary care physician’s referral preference or covering physician; or
- Emergency Services call schedule

j. **Response Time:** It is the responsibility of the physician to respond in an appropriate time frame. Physicians should respond to calls from the Emergency Department or the Hospital within 30 minutes. If required by the Emergency Department physician, it is expected that physicians arrive in the Emergency Department within 1 hour of initial contact or at a time determined by the Emergency Department physician. If a physician does not respond to being called or paged within 30 minutes, the nursing staff shall follow current call protocols. Failure to respond in a timely manner may result in the initiation of disciplinary action.

k. **Substitute for Call:** In the event the physician is unable to fulfill their call obligation, it is their responsibility to arrange for a substitute and notify the Emergency Department. Failure to notify the Emergency Department of a substitute for call may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the call/coverage physician and no admission is deemed necessary, the Emergency Department physician shall provide appropriate care/treatment and discharge the patient with arrangements made for follow-up care. It is the call/coverage physician’s responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit. The timeframe of the follow-up visit shall be based on discussion between the Emergency Department physician and the call/coverage physician. The Emergency Department physician has the ability to unilaterally determine the timeframe of the follow-up visit. Failure to comply may result in disciplinary action as determined by the MEC.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department shall be referred to the physician taking call that day. Physicians who have a previous relationship with a returning unassigned patient may be called to see if they want to continue to care for the patient, but are under no obligation to do so.
2.3 Transfers

2.3.1 Patient Transfers from Other Acute Care Facilities

Patient transfers from other acute care facilities shall meet the following criteria:

a. The patient shall be medically stable for transfer;

b. The patient’s condition shall meet medical necessity criteria for admission;

c. The Hospital shall have the capability and capacity to treat the patient; and

d. Responsibility for the patient shall be accepted by a physician with admitting privileges at the Hospital.

2.3.2 Emergency Department Transfers

The Hospital shall accept all appropriate transfers of individuals who require the specialized capabilities or facilities available of the Hospital as long as the Hospital has the capability and capacity to treat the individual. Such transfers are described in the Emergency Medical Treatment and Labor Act, and may include a screening evaluation by an Emergency Department physician.

2.3.3 Transfers within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. The attending physician shall be required to authorize all transfers to a different level of care.

2.3.4 Transfers to another Hospital

The transfer of patients to other acute care hospitals shall be done in accordance with the Hospital’s guideline on referral and transfer of patients.

2.4 Patients who are a Danger to Themselves or Others

The attending physician is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Admissions of suicidal patients shall not be accepted except for those patients requiring medical stabilization. Once the patient’s medical condition is stabilized, the patient shall be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

2.5 Prompt Assessment

Patients admitted shall be personally examined and evaluated by the attending physician or his/her designee within 24 hours. Unstable patients shall be seen as soon as possible in a time period dictated by the acuity of their illness.
2.6 **Discharge Orders and Instructions**

Patients shall be discharged or transferred only upon the order of the attending physician or his/her designee who shall provide, or assist Hospital personnel in providing, written discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient’s care. These instructions should include, if appropriate:

- a. A list of all medications the patient is to take post-discharge;
- b. Dietary instructions and modifications;
- c. Medical equipment and supplies;
- d. Instructions for pain management;
- e. Any restrictions or modification of activity;
- f. Follow up appointments and continuing care instructions;
- g. Referrals to rehabilitation, physical therapy, and home health services; and
- h. Recommended lifestyle changes, such as smoking cessation.

2.7 **Discharge Against Medical Advice**

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital guidelines shall be followed. The attending physician shall be notified that the patient has left against medical advice.

**ARTICLE III**

**MEDICAL RECORDS**

3.1 **Authentication of Entries**

All clinical entries in the patient’s medical record shall be accurately dated, timed, and authenticated (signed) with the practitioner’s legible signature or by approved electronic means.

3.2 **Clarity, Legibility, and Completeness**

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviation and symbols) shall not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual shall contact the practitioner, request clarification, read back the order, and enter the clarification in the medical record. This clarification shall be signed by the ordering practitioner as described in Subsection 4.3.2.
The clarity, completeness, and legibility of medical record documentation should be considered in evaluating the practitioner at the time of reappointment. Practitioners whose medical record entries are habitually unclear, incomplete, or illegible should be subject to corrective action as determined by the Medical Executive Committee.

3.3 Abbreviations and Symbols

The use of abbreviations and symbols in the medical record shall be consistent with the following rules:

**Standard Abbreviations:** Only standard symbols and abbreviations shall be used. To be considered “standard,” the symbol or abbreviation shall be listed in the most recent edition of Stedman’s Medical Abbreviations, Acronyms, and Symbols. If a non-standard symbol or abbreviation is used, its full meaning shall be explained on the same page.

**Prohibited Abbreviations, Acronyms, and Symbols:** The Medical Staff shall comply with the list of ‘Do Not Use’ abbreviations as currently required by The Joint Commission.

3.4 Correction of Errors

Medical records shall not be altered, except when necessary to correct an error:

a. A single line shall be drawn through the erroneous entry; under no circumstances should the original entry be obscured;

b. The corrected entry shall be authenticated with the practitioner’s signature and the date and time.

3.5 History and Physical Examination

3.5.1 Who May Perform and Document the History and Physical Examination

1. Pursuant to the Medical Staff Bylaws, Volume I, Article II, a Practitioner holding Clinical Privileges at the Hospital must complete a physical examination and medical history for each patient; or update/validate a physical examination and medical history completed by a Practitioner outside of the Hospital no more than thirty (30) Days before or twenty-four (24) hours after admission or registration. The Medical Executive Committee may, at its discretion, specify in Medical Staff Policies additional Practitioners who may perform histories and physicals.

2. All individuals presenting to the Hospital’s Emergency Services Department will be provided a medical screening examination to determine if an emergency medical condition exists. This examination may be performed by a physician, advanced practice nurse, physician assistant, or by “qualified medical personnel” other than a physician, advanced practice nurse, or physician assistant, consistent with the scope of practice as determined by State law.
“Qualified medical personnel” is defined as a registered nurse who has attained core obstetrics competencies such that he/she is able to assess a patient for the presence of active labor. If a medical screening examination is conducted by a non-physician practitioner, that individual shall immediately involve the Emergency Services physician on duty or his/her designee when, in his/her clinical judgment, the medical screening examination exceeds his/her expertise, scope of practice and/or the patient’s condition requires evaluation by a physician.

3.5.2 Compliance with Documentation Guidelines

The minimal content of the history and physical for all patients includes: chief complaint, past medical and surgical history, documentation of review of medications and allergies, relevant physical examination, assessment, and plan for care.

For outpatient services related to minor scheduled treatments such as blood transfusions, therapeutic phlebotomies, medication administration, contrast administration, a complete H&P is not required, but orders with indications for the test/treatment must be documented in the medical record by the ordering physician.

Patients admitted for General Inpatient Hospice services require an order for admission from the attending physician or Hospice Medical Director; progress notes, if any visit(s) are made during the stay; and a care plan signed by the attending physician or Hospice Medical Director. History and physicals, routine visits, and discharge summaries are not required.

3.5.3 The attending physician is responsible for the History and Physical Examination.

3.6 Pre-Operative Documentation

Except in an emergency, a history and physical examination shall be documented in the medical record prior to any procedure requiring more than local anesthesia for all patients undergoing surgery and/or any patient expected to be admitted after surgery. The Surgical Services Manager has the authority to cancel or delay the surgical procedure if the history and physical is not available on the chart. In certain circumstances, the Surgical Services Manager may permit the patient to be transferred to the Pre-Anesthesia area for performance of the history & physical.

3.7 Progress Notes

The attending physician, or his/her designee, shall record a progress note each day and at the time of each significant patient encounter on all hospitalized patients. Progress notes shall document the reason for continued hospitalization.

Hospitalized surgical patients shall be seen by the surgeon performing the procedure or their coverage designee for a pre-operative evaluation, on post-operative-day one, and prior to discharge or sign off of care, with the concurrence of the attending physician. For
simple procedures, the surgeon may sign off on the day of surgery, with the concurrence of the attending physician.

3.8 Operative/Procedure Reports

Operative/procedure reports shall be documented or dictated immediately after surgery/procedure (before the end of the day) and the report promptly signed by the surgeon and made a part of the patient’s medical record. Operative reports shall include all items as required by CMS, The Joint Commission, and the Hospital Licensing Act.

3.9 Operative/Procedure Notes

If there is a transcription delay, an interval operative/procedure note is recorded in the progress notes, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes shall include all items as required by CMS, The Joint Commission, and the Hospital Licensing Act.

3.10 Anesthesia Assessments

For all patients undergoing general anesthesia or deep sedation there shall be a pre-anesthesia assessment, an intraoperative anesthesia record, and a post-anesthesia note. The post-anesthesia note shall be completed within twenty-four (24) hours of the completion of anesthesia and prior to discharge home. It shall contain all items as required by CMS, The Joint Commission, and the Hospital Licensing Act.

In addition, an immediate pre-sedation assessment shall be documented by anesthesia before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered.

3.11 Consultations

Emergent consultations require physician to physician communication regarding the reason for the consultation and the expected timeframe of completion. Non-emergent consultations shall be ordered in the physician orders defining 1) who is to be consulted and 2) the reason for the consultation. All consultations are expected to be completed within twenty-four (24) hours, following notification, unless otherwise specified. A short summary of the consultation shall be entered into the medical record at the time of completion of the consultation.

3.12 Obstetrical Record

The office prenatal record will suffice for a normal obstetric patient’s history & physical as long as it is updated to the time of admission. Normal newborn H&P's are documented on the newborn record.
3.13 Discharge Summaries

All discharge summaries shall be the responsibility of the attending physician or his/her designee.

a. Content: A clinical summary shall be documented or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the attending physician and shall contain:
   1. Reason for hospitalization;
   2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
   3. Condition of the patient at discharge;
   4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
   5. Final diagnoses.

b. Short-term Stays: A discharge summary is not required for uncomplicated stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician enters a final progress note or completes a discharge form documenting:
   1. The condition of the patient at discharge; and
   2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

   If the entire stay is less than twenty-four (24) hours a summation note containing all requirements for a history and physical examination and the discharge summary may be used.

c. Deaths: A clinical summary is required on all patients who have expired and shall include:
   1. Reason for admission;
   2. Summary of hospital course;
   3. Final diagnoses; and

d. Timing: A Discharge Summary shall be entered in the medical record within ten (10) days of discharge, transfer, or death.
3.14 **Diagnostic Reports**

Diagnostic reports (including but not limited to EKGs, echocardiograms, stress tests, Doppler studies, EEGs and pulmonary function tests) shall be read by the physician scheduled to provide the interpretation in a timeframe determined by contract or by the appropriate clinical service. Diagnostic tests may be ordered as a stat read. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

3.15 **Authentication of Outside Records**

Pre-registration and admission ancillary tests, from outside entities, should be included on the patient's medical record if the patient's physician signs off on the test results attesting to the authenticity of the test results.

3.16 **Access and Confidentiality**

A patient’s medical record is the property of the Hospital. If requested, the record shall be made available to any member of the Medical Staff admitting the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records shall otherwise be disclosed only pursuant to court order, subpoena, or statute. Records shall not be removed from the Hospital’s jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records**: In case of readmission of a patient, all previous records shall be made available to the attending practitioner or any other involved practitioners, whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall have prior approval of the Institutional Review Committee. The written request shall include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests shall be presented to the Health Information Manager.

d. **Access for Former Members**: Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
3.17 Medical Record Completion

A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

3.17.1 Requirements for Timely Completion of Medical Records

Medical records shall be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination shall be in the medical record within 24 hours of admission;

b. A Pre-operative/pre-procedure History and Physical Examination or Focused Pre-operative/pre-procedure History and Physical Examination shall be entered in the medical record prior to the surgery or procedure for any patients undergoing surgery and/or any patient expected to be admitted after surgery, with the exception of emergency surgery;

c. An Admission Prenatal Record shall be entered in the medical record by the attending physician or designee within 24 hours of an obstetrical admission;

d. An operative/procedure Report shall be entered in the medical record by the performing practitioner immediately following the surgery or procedure, in no case later than midnight of the day of the procedure;

e. Progress Notes shall be recorded and authenticated by the attending physician or designee on a daily basis and at the time of each significant encounter; excluding day of admission and day of discharge;

f. An Emergency Department Record shall be completed by the responsible practitioner by the end of day of the shift worked;

g. A consultation note shall be completed by the consulting physician, or designee, within 24 hours of the consult request, unless stipulated otherwise;

h. If a discharge summary is required, it shall be entered in the medical record by the attending physician or his/her designee within 10 days of discharge, transfer, or death;

i. The medical record shall be completed within twenty-one (21) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

3.17.2 Voluntary Relinquishment of Clinical Privileges for Incomplete Records

Concurrent data collection of late Histories and Physicals and Operative Reports and Emergency Department medical records and Consultation reports shall be conducted on an ongoing basis. Histories and Physicals are considered to be late if documented greater than 24 hours after admission. Operative Reports are considered to be late if not documented on the day of the procedure. Emergency Department medical records are considered to be late if not completed by the designated Emergency Department physician by the end of the day of his/her shift worked. Consultation reports are considered late if not documented by the consulting physician, or designee, within 24 hours of the consult request, unless stipulated otherwise.
The first time a physician has a total of five or more late reports in a month, he/she shall be required to appear before the Medical Executive Committee. The second time a physician has five or more late reports in a month for the most recent 12-month period, he/she shall be required to appear before the Medical Executive Committee and provide a written action plan to improve compliance. The third time a physician has five or more late reports in a month for the most recent 12-month period, he/she shall be considered to have voluntarily resigned from the Medical Staff. To regain medical staff membership and privileges following such a resignation, the physician shall be required to re-apply for medical staff membership.

3.18 Medical Students

a. Medical students may perform and document histories & physicals, as well as discharge summaries, progress notes, and operative/procedure notes. All documentation shall be reviewed and countersigned by the attending physician or his/her designee.

b. The method of signature which shall be used by medical students is “medical student’s name — MS III or MS IV”

ARTICLE IV
STANDARDS OF PRACTICE

4.1 Attending Physician

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The attending physician, or designee, shall be responsible for:

a. The care of the patient.

b. Documentation of the following items:

1. The admission history and physical examination;

2. Daily rounds documenting the patient’s course of medical treatment;

3. The discharge summary.

4.1.2 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff appointee, a note covering the transfer of responsibility shall be noted in and mutually agreed upon in the medical record.
4.2 Responding to Calls and Pages

Practitioners are expected to respond promptly, within thirty (30) minutes, to calls from the Hospital’s patient care staff. If the Practitioner does not respond in thirty (30) minutes, the staff is to follow the existing nursing policy on calling alternate providers in the case of non-responsiveness to calls. Failure to respond to calls and pages in accordance with this section may result in the initiation of MEC review and disciplinary action, consistent with the Medical Staff Bylaws.

4.3 Orders

4.3.1 General Principles

a. All orders for treatment shall be documented.

b. Orders shall be clear and unambiguous.

c. All orders shall be specifically given by a practitioner, or designee, who has privileges at St. Anthony’s.

d. Vague, ambiguous, or “blanket” orders (such as “continue home medication” or “resume previous orders”) shall not be accepted.

e. Instructions shall be documented in English. ‘Do Not Use’ abbreviations shall not be used.

f. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible signature, date, and time.

g. The medical staff authorizes those practitioners who are not medical staff members to be able to order non-invasive laboratory and radiologic tests. The ordering practitioner shall be listed on the registration and shall receive copies of the test or treatment reports.

h. A Medical Staff member may give an order authorizing a patient’s admission or authorizing diagnostic tests or procedures to any of the disciplines listed in Section 4.4.3 or to a secretary, business office clerk, or scheduler.

4.3.2 Verbal and Telephone Orders

Face-to-face verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal and telephone orders shall comply with the following criteria:

a. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal orders, like documented orders, should be conveyed in English without the use of prohibited abbreviations.
b. The order shall be read back to the prescribing practitioner by the authorized person receiving the order.

c. All verbal orders given in person shall be signed in compliance with CMS and Joint Commission standards.

4.3.3 Receipt of Verbal or Telephone Orders

Credentialed providers shall give telephone and verbal orders for medications and treatments only to other privileged practitioners, registered nurses, licensed practical nurses, or to certified professional persons who are authorized by law to administer or dispense the medication or treatment in the course of practicing their identified specific disciplines, i.e., physician, registered pharmacist, physical therapist, occupational therapist registered, licensed speech-language pathologist, radiologic technologist, licensed respiratory care practitioner, medical laboratory technician, and dietitian.

4.3.4 Orders Following Surgery or Transfer

All previous orders are suspended when the patient:

a. goes for a procedure requiring more than local anesthesia,

b. transferred to a different level of care, either higher or lower, or

c. transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically entered following surgery or the aforementioned transfers. Instructions to “resume previous orders” shall not be accepted.

4.3.5 “Stat” Orders

“Stat” or “now” orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. “Stat” and “now” orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of “stat” and “now” orders can result in disciplinary action from the MEC.

4.4 Consultation

a. Physicians are responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges.

b. Except in an emergency, consultation is recommended in the following situations:

1. When the patient is not a good risk for operation or treatment;
2. Where the diagnosis is obscure after usual diagnostic procedures have been completed;

3. Where there is doubt as to the choice of therapeutic measures to be utilized;

4. In unusually complicated situations where specific skills of other practitioners may be needed;

5. When requested by the patient or his/her family.

c. The physician shall provide documented authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his/her patient. This request shall specify:

1. the reason for the consultation;

2. the urgency of the consultation (emergent—within the timeframe communicated by the practitioners; or non-emergent—within 24 hours);

3. emergent consults require physician to physician communication.

d. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall first call this to the attention of the patient's ordering physician. If the situation is not resolved to the nurse's satisfaction he/she should then bring this matter to the attention of his/her supervisor who should consult with the patient's attending physician or refer the matter to the Chief of the Clinical Service to which the patient's attending physician is assigned. Further resolution may require notification and consultation with the President of the Medical Staff or designee and the Administrator on-call. Where circumstances are such as to justify such action, or in an emergency, the Clinical Service Chief, President of the Medical Staff, or the Administrator on-call or their designee may request a consultation.

4.5 **Death in Hospital**

4.5.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased shall be pronounced by the attending practitioner, his/her designee, or nursing staff within a reasonable time. The physician who last treated the patient, or the coroner in appropriate cases, is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.5.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.
4.6 Autopsy

It is the duty of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico legal or educational interest. A provisional anatomic diagnosis shall be recorded on the medical record within three (3) days, and the complete autopsy report shall be made part of the medical record within thirty (30) days unless an explanatory note is entered.

4.7 Advanced Practice Professionals

4.7.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, including Advanced Practice Registered Nurses and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals shall provide care only under the supervision (for physician assistants) or collaboration (for advanced practice nurses) of a physician who is an appointee to the Medical Staff (collectively referred to herein as “supervision”). Advanced Practice Professionals are not eligible for Medical Staff membership.

4.7.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician is responsible for coordinating and managing the care of patients and the supervision of the Advanced Practice Professional in all settings.

b. Health care services delivered by Advanced Practice Professionals under physician supervision shall be within the scope of granted clinical privileges.

c. The physician shall be available for consultation at all times, either in person or through telecommunication systems or other means.

d. Advanced Practice Professionals may write daily progress notes but they are not official until cosigned by the supervising physician each day. The signature signifies that the attending or supervising physician has reviewed the patient’s medical record and approved the care rendered by the Advanced Practice Professional.

e. Patients should be made aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

f. The supervising physician is responsible for clarifying and familiarizing the Advanced Practice Professional with his/her supervision methods and style of delegating patient care.
4.7.3 Collaborative Practice Agreements

Each Advanced Practice Professional shall have on file in the Medical Staff Services Office written Supervision/Collaborative Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional.

4.7.4 Supervising Physician

An Advanced Practice Professional should not provide services to patients if the supervising physician is more than sixty (60) minutes travel time from the Hospital. A physician should not supervise more than four (4) Advanced Practice Professionals at any one point in time.

The Medical Executive Committee may grant or revoke an exception to the sixty (60) minute travel time requirement upon a recommendation by the respective Clinical Service and the Medical Staff.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.7.5 Medical Record Documentation

Advanced Practice Professionals may enter progress notes within the scope of granted clinical privileges, however require co-signature. History and physical examinations performed by Advanced Practice Professionals require co-signature within two (2) days. Consultation notes entered by Advanced Practice Professionals shall be co-signed within twenty-four (24) hours of the initiation of the consultation. Discharge summaries dictated by Advanced Practice Professionals shall be cosigned within twenty one (21) days after discharge.

Orders written by Advanced Practice Professionals and Post-operative notes by Certified Registered Nurse Anesthetists are exempt from the co-signature requirement.

4.7.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional shall not:

a. provide a service outside the scope of granted clinical privileges;
b. prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented in the Supervision/Collaborative Agreement; and
c. provide a medical service that exceeds the clinical privileges granted to the supervising physician.
4.8 **Infection Control**

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties.

4.9 **Evidence-Based Medicine Order Sets**

Evidence-based medicine order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The Quality Council may adopt evidenced-based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

**ARTICLE V**

**PATIENT RIGHTS**

5.1 **Patient Rights**

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 **Informed Consent**

The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner’s obligation is to present the medical facts accurately to the patient, or the patient’s surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient’s authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy ‘Informed Consent and “Consent for Procedure” Form.

5.3 **Withdrawing or Withholding Life Sustaining Treatment**

Hospital policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that shall occur when withdrawing or withholding life-sustaining treatment.

5.4 **Do Not Resuscitate Orders**

The Hospital policy on ‘Do Not Resuscitate’ delineates the responsibilities, procedure, and documentation that shall occur when initiating or cancelling a Do Not Resuscitate order.
5.5 **Disclosure of Unanticipated Outcomes**

The Hospital policy on ‘Disclosure of Unanticipated Outcomes’ delineates the responsibilities, procedure, and documentation that shall occur when an unanticipated outcome does occur.

5.6 **Restraints and Seclusion**

The Hospital policy on ‘Restraints and Seclusion for Hospitalized Patients’ delineates the responsibilities, procedure, and documentation that shall occur when ordering restraints or seclusion.

5.7 **Advance Directives**

The Hospital guideline on ‘Advance Directives’ delineates the responsibilities, procedure, and documentation that shall occur regarding advance directives.

5.8 **Investigational Studies**

Investigational studies and clinical trials conducted at the Hospital shall be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy shall be followed.

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**ARTICLE VI**

**SURGICAL CARE**

6.1 **Surgical Privileges**

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as recommended by the Medical Executive Committee and approved by the Board. Surgical privileges shall be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner.

6.2 **Surgical Policies and Procedures**

All practitioners shall comply with the Hospital’s surgical policies and procedures. These policies and procedures shall cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.
6.3 **Anesthesia**

Any sedation greater than mild sedation and any anesthesia greater than local anesthesia should only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist shall maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient’s condition for each patient receiving deep sedation and anesthesia. The practitioner responsible for the ordering the administration of moderate sedation shall document a pre-sedation evaluation and post-sedation follow-up examination.

6.4 **Tissue Specimens**

Specimens removed during the operation shall be sent to the Hospital pathologist who shall make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist’s report shall be made a part of the patient’s medical record.

6.5 **Verification of Correct Patient, Site, and Procedure**

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention shall be identified by an ID wrist band with the patient’s name the patient’s date of birth. The Hospital policy on ‘Surgical/Invasive Procedure Verification’ shall be followed.

**ARTICLE VII**

**RULES OF CONDUCT**

7.1 **Disruptive Behavior**

7.1.1 **General Guidelines**

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is defined as behavior that is disruptive to the operations of the Hospital and/or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Corporate policies on ‘Code of Conduct’ and ‘Corporate Compliance Plan’ shall be followed.
7.1.2 Procedure of Validation and Intervention

Procedure: Practitioners agree to act in a manner consistent with these values and principles. The Partnership Committee shall evaluate and assist practitioners in complying with these principles. When practitioners are observed violating these principles and feedback, as defined in III. E. is not effective, the behavior shall be documented and sent to the CMO and appropriate Clinical Service Chief. Documentation of the behavior shall be considered confidential and include all relevant information needed to remedy the situation.

Most issues should be handled at the level of Clinical Service Chief or CMO. If further needs are identified by the CMO, MEC, Clinical Service Chief, or a Medical Staff Committee, the issue shall be sent to the Partnership Committee.

Actions:
The Partnership Committee shall meet with involved persons and necessary Administration. The committee shall then weigh the severity of the occurrence.

Those occurrences determined to be minor shall result in the practitioner knowing the expectations that are required of him/her. Trending of the practitioner shall occur to assess if repeated minor events warrant performance improvement.

Further Actions:
Partnership Committee shall make recommendations to the Medical Executive Committee concerning behavior not covered above. These recommendations may be amended but are binding to the practitioner involved. They may include, but are not limited to, a referral to the Wellness Committee, referral to an outside agency, i.e., IPHP, or there may be internal follow-up.

7.2 Reporting Impaired Practitioners

Reports and self referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff policy ‘Fitness for Duty’.
References

‘Do Not Use’ Abbreviations – TJC IM.02.02.01, EP 3

- U,u for Units
- IU for International Units
- Q.D., QD, q.d., qd for Daily
- Q.O.D., QOD, q.o.d., qod for Every Other Day
- Trailing Zero (X.0)
- Lack of Leading Zero for Numbers Less than Zero (.X)
- MS or MSO4 for Morphine Sulfate
- MGSO4 for Magnesium Sulfate

Operative report requirements – TJC RC.02.01.03, EP 6, CMS Tag A-0959 (§482.51(b)(6))

- the name of the licensed independent practitioner(s) who performed the procedure and any assistants,
- the name of the procedure performed,
- a description of the procedure performed,
- findings of the procedure,
- any estimated blood loss,
- any specimen(s) removed, and
- the post-operative diagnosis.

Operative note requirements – TJC RC.02.01.03, EP 7

- the name of the licensed independent practitioner(s) who performed the procedure and any assistants,
- the name of the procedure performed,
- findings of the procedure,
- any estimated blood loss,
- any specimen(s) removed, and
- the post-operative diagnosis.
Post-anesthesia note requirements – CMS Tag A-1005 (§482.52(b)(3))

- respiratory function (respiratory rate, airway patency, oxygen saturation),
- cardiovascular function (heart rate and blood pressure),
- mental status,
- temperature,
- pain,
- nausea and vomiting, and
- postoperative hydration.